STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC	300 J H WALKER DRIVE PENDLETON, IN46064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure survey. Survey dates: March 1, 2, 3, 4, and 7, 2011 Facility number: 000248 Provider number: 155357 AIM number: 100291470 Survey team: Tammy Alley RN TC Donna M. Smith RN Toni Maley BSW Karen Lewis RN (March 3, 2011) Census bed type: SNF/NF: 93 Residential: 46 Total: 139 Census payor type: Medicare: 20 Medicaid: 44 Other: 75 Total: 139 Sample: 19 Residential: 7 Supplemental Sample: 19 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is: April 6, 2011. -	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 3-10-11 Cathy Emswiller RN			
F0160 SS=B	Based on record review and interview, the facility failed to ensure resident funds were dispersed within 30 days of resident discharge from the facility for 10 of 10 discharged residents reviewed for account dispersion in a supplemental sample of 19. (Resident #'s 104, 105, 106, 107, 108, 109, 110, 111, 112, and 113) Findings Include: 1. An undated policy titled "Resident Funds Policy" was provided by the Administrator on 3/7/11 at 10 a.m., and deemed as current. The policy indicated: "...12. Closing an Account: In case of death or discharge, a final accounting of a resident's personal funds is completed including payment of any outstanding balances due the facility. The balance remaining will be conveyed within 30 days to the individual or probate jurisdiction administering the resident's estate...." 2. Resident funds were reviewed on 3/7/11 at 9 a.m. The following discharged residents had outstanding balances in the Resident Trust Account greater than 30	F0160	**F 160** I. Resident # 104, Resident #105, Resident #106, Resident #107, Resident # 108, Resident #109, Resident #110, Resident #112 and Resident #113 accounts were closed 3/21/11 II. After review, all discharged residents in the last 30 days were reviewed for dispersement of funds and no issues were identified, other than the residents identified in the survey. III. The systemic change is that the facility policy has been amended to include monthly report for all discharges. The Business Office manager received education regarding these systemic changes. Resident funds will be reviewed on a monthly basis in addition to quarterly review. IV. 100% of discharges will be reviewed by the Business Office Manager and a report will be submitted to the Administrator of findings, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days to total 12 months. Results of report findings will be reported to the QA committee monthly for 12 months, to assist with additional recommendations if necessary. COMPLETION DATE: April 6, 2011.	04/06/2011

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	days after discharge from the facility. Resident # 104: discharged on 1/911 with a balance of $480.31 Resident # 105: discharged on 3/26/10 with a balance of $.20 Resident # 106: discharged on 12/18/10 with a balance of $20.00 Resident # 107: discharged on 1/26/11 with a balance of $ 226.65 Resident # 108: discharged on 12/5/10 with a balance of $ 50.09 Resident # 109: discharged on 3/27/09 with a balance of $.02 Resident # 110: discharged on 3/15/10 with a balance of $.02 Resident # 111: discharged on 8/22/10 with a balance of $ .03 Resident # 112: discharged on 12/22/10 with a balance of $ 50.01 Resident # 113: discharged on 1/7/11 with balance of $ 100.03 On 3/7/11 at 9:10 a.m., during interview, the Business Office Manager indicated she was unsure of the time frame to close discharged resident accounts. She indicated she had not been trained on the resident trust account. She indicated there was a corporate consultant who was managing the resident funds accounts. On 3/7/11 at 10 a.m., during interview,			

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	the administrator indicated she was aware the accounts had not been closed within 30 days. 3.1-6(h)			
F0161 SS=B	Based on record review and interview, the facility failed to have a Surety Bond in a sufficient amount to protect the funds in the Resident Trust Account. The deficient practice had the potential to affect 54 of 54 residents the facility managed funds for. Findings Include: 1. An undated policy titled "Resident Funds Policy" was provided by the Administrator on 3/7/11 at 10 a.m., and deemed as current. The policy indicated: "...2. Security: Funds maintained by the facility are protected by company insurance and evidence of this security is available for inspection by authorized representatives of state and federal agencies...." 2. During review of the facility's Surety Bond on 3/7/11 at 8:10 a.m., the bond amount was for $25,000. The Resident Trust Account daily balances was reviewed on 3/7/11 at 8:10	F0161	**F-161** I. The new Surety Bond has been put into place and now covers the cumulative balance in the Resident Trust Account. II. There were no other resident accounts that were larger than the Surety Bond. III. The systemic change includes a new monthly report with the Resident Trust Account. This report will be completed and provided to the Administrator on a monthly basis. The Business Office Manager will be provided education on this process and providing this report to the Administrator. IV. The Business Office Manager and Administrator will be responsible to audit the Resident Trust Account, 5 accounts per week for 30 days, then 5 accounts per month for 150 days, then 3 accounts per month for 180 days to total 12 months of auditing. Results of monthly reports will be reported to the QA committee monthly for 12 months, to assist with additional recommendations if necessary. COMPLETION DATE: April 6, 2011.	04/06/2011

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	a.m. On the following dates the Trust Account balance was greater than the Surety Bond amount. 12/7/10: balance $34,032 12/13/10: balance $34,012.58 12/15/10: balance $33,962.58 12/17/10: balance $35,608 12/23/10: balance $37,270 12/29/10: balance $38,641.10 1/5/11: balance $39,468.40 1/13/11: balance $39,069.66 1/14/11: balance $40,869.78 2/6/11: balance $35,608 2/13/11: balance $36,578.92 2/28/11: balance $39,468.40 On 3/7/11 at 9:10 a.m., during interview, the Business Office Manager indicated she indicated she had not been trained on the resident trust account but there was a corporate consultant who was working on the fund account. On 3/7/11 at 10 a.m., during interview, the administrator indicated she was aware the Surety Bond was not a sufficient amount to protect the Resident Trust Account. 3.1-6(i)			

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F0223 SS=A	Based on record review and interview, the facility failed to prevent verbal abuse from occurring for 1 of 1 reportable allegation of abuse in a supplemental sample of 19. (Resident # 104) Finding Include: 1. A 8/09 policy titled "Abuse Prevention" was provided by the Administrator on 3/1/11 at 12 p.m., and deemed a current. The policy indicated: "It is the policy of CarDon & Associates to provide each resident with an environment that is free form verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. we have established policies and procedures that will provide facility personnel with the knowledge and training to further ensure each resident is treated with individual respect and dignity...Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability...." 2. A "Facility Incident Reporting Form" dated 6/5/10 was reviewed on 3/2/11 at 9	F0223	**F-223** I. Resident had no recall of the incident at the time. II. Employee was terminated immediatly.Residents were interviewed with no additional findings.III. Systemic change is that all new hires, as well as, all staff competencies will be educated on abuse and reporting abuse, IV. The Human Resource Director or designee will monitor and give a monthly report on all new hire files and annual staff competencies for staff abuse and prevention training, 5 times per week for 30 days, then 5 times a month for 150 days, then 3 times per month for 180 days for 12 months of monitoring. Results of monitoring will be reported to the QA committee, per month, for 12 months, with additional recommendations as necessary.	04/06/2011

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	a.m. The report indicated a housekeeper was overheard telling Resident # 104 "you better shut your mouth or I will rip your tongue out." The event was reported immediately and the employee suspended pending the investigation. During the investigation the employee indicated "...we joke like that all the time..." The employee was terminated and the resident did not recall the event. During interview on 3/7/11 at 1 p.m., the Administrator indicated she was not employed by the facility at the time of the above event and had no information to provide. 3.1-27(b)			

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F0315 SS=D	Based on observations, interviews, and record reviews, the facility failed to ensure Foley catheter (F/C) bags were positioned below the resident's bladder level during transfers and F/C care was provided during personal care in a manner to prevent urinary tract infections for 1 of 1 residents observed with Foley catheter in a sample of 19. (Resident #13) Findings include: 1. The "Catheter Care, Urinary" policy was provided by the Director of Nursing on 3/04/11 at 11:25 a.m. This current policy indicated the following: "Purpose The purpose of this procedure is to prevent infection of the resident's urinary tract. ...General Guidelines ...4. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder....." 2. On 3/01/11 at 4:25 p.m., Resident #13's Hoyer lift transfer was observed. In preparation, CNA #12 was observed to	F0315	**F-315** I. Resident #13's catheter tubing and Foley catheter bag was re-positioned below the level of the bladder. Catheter tubing was cleansed. II. All residents with Foley catheters have been identified and were monitored for correct positioning and appropriate cleansing of the catheter tubing and no issues were identified. III. The systemic change is that all new hire C.N.A.' s will receive education on proper positioning of catheters, including during transfers and cleaning catheter tubing during peri care. Education was completed on 3/10/11on proper positioning and cleansing of Foley catheter tubing and transfers with foley catheters. Charge nurses received education on observing resident care to determine that catheters are handled in a manner to prevent urinary tract infections... IV. The Unit Manager or designee will audit Foley catheter tubing, bag positioning, transfers with Foley catheters Foley catheter care and cleansing catheter tubing on all shifts, 5 residents per week for 30 days then 5 residents per month for 150 days then 3 residents per month for 180 days to total 12 months of monitoring. Results of audits will be reported to the QA committee monthly, for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #1 regarding:	04/06/2011

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	hold the resident's urinary drainage bag above the resident's bladder level as she checked the amount of urine in the bag. She indicated she would need to empty his urinary drainage bag prior to the transfer. Cloudy, dark yellow urine was observed in the urinary drainage bag and Foley Catheter (F/C) tubing. On 3/02/11 from 1:10 p.m. to 1:30 p.m., Resident #13's transfer with the Hoyer lift and personal care were observed. Upon entering the room, CNA #21 was observed transferring the resident from his bed to his wheelchair with his Foley catheter (F/C) bag in his lap. After lowering the resident into his bed, the Hoyer lift was removed from the room. After CNA #21 returned to the resident's room, she lowered the resident's F/C bag down below the bladder. Cloudy, yellow urine was observed in the F/C tubing. After undressing the resident, CNA #21 was observed to cleanse Resident #13's front peri-area in a sweeping motion from one side of the groin, under the testicles, over the lower abdomen, and then, to the other side of the groin 3 different times. No catheter tubing cleansing was observed. After turning the resident, rectal care was completed with a small amount of brown bowel movement observed on the washcloth. CNA #21		Foley Catheter Care Audit. Please see revised attachment #2 regarding: Foley Catheter Tubing Positioned Correctly. COMPLETION DATE: April 6, 2011. **F-315** I. Resident #13's catheter tubing and Foley catheter bag was re-positioned below the level of the bladder. Catheter tubing was cleansed. II. All residents with Foley catheters have been identified and were monitored for correct positioning and appropriate cleansing of the catheter tubing and no issues were identified. III. The systemic change is that all new hire C.N.A.' s will receive education on proper positioning of catheters, including during transfers and cleaning catheter tubing during peri care. Education was completed on 3/10/11on proper positioning and cleansing of Foley catheter tubing and transfers with foley catheters. Charge nurses received education on observing resident care to determine that catheters are handled in a manner to prevent urinary tract infections... IV. The Unit Manager or designee will audit Foley catheter tubing, bag positioning, transfers with Foley catheters Foley catheter care and cleansing catheter tubing, 5 residents per week for 30 days then 5 residents per month for 150 days then 3 residents per month for 180 days to total 12 months of monitoring. Results of audits will be reported	

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	then completed his care and repositioned him before exiting the room. At this same time during an interview, CNA #21 indicated the F/C bag should be kept below the bladder level at all times. 3. Resident #13's record was reviewed on 3/01/11 at 4:10 p.m. The resident's diagnoses included, but were not limited to, profound benign prostatic hypertrophy, urinary retention, and Alzheimer's dementia. The significant minimum data set assessment, dated 2/14/11, indicated the resident was moderately cognitively impaired. The resident had an indwelling catheter. The physician order, dated 12/07/10, was Ceftin (antibiotic) 500 milligrams by mouth 2 times a day for 7 days for a urinary tract infection. The final report for the urine culture, dated 12/08/10, indicated the growth of Escherichia Coli. 3.1-41(a)(2)		to the QA committee monthly, for 12 months, to assist with additional recommendations if necessary. COMPLETION DATE: April 6, 2011.	

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F0323 SS=E	Based on observations, interviews, and record review, the facility failed to ensure personal body alarms (PBA's) were turned on and functional for 5 of 7 residents reviewed with PBA's (Resident #'s 27, 29, 25, 44, and 16) and to ensure precautions were followed during the use of a Hoyer lift for 1 of 1 resident observed (Resident #13) during 1 of 2 Hoyer lift transfers in a sample of 19. Findings include: 1. On 3/01/11 from 5:30 p.m. to 6:25 p.m. during dinner observation, the following was observed: a.) Resident #27's personal body alarm (PBA) was observed in the "off" position. At this same time during an interview, CNA #18 indicated the PBA was off as he turned it on. Resident #27's record was reviewed on 3/07/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, Parkinson's, dementia, debility, and history of vertigo. The annual minimum data set assessment, dated 12/15/10, indicated the resident's cognition was moderately impaired. The resident required extensive assistance of 1 to 2 persons for transfers and toileting. The	F0323	**F-323** I. Residents #27, #29, #25, #44, and #16 were reviewed and all alarms were placed appropriately in accordance to care plan. #21 C.N.A. was provided education on using the Hoyer lift. The resident is safely transferred in the lift. II. All other residents with personal body alarms were reviewed during the survey and found to be appropriate and in accordance with the care plans. All other residents who use the Hoyer lift were reviewed during survey and found to be transferred appropriately. III. The systemic change is that all newly hired C.N.A.'s and annual competencies with all C.N.A.'s will be educated on alarms and usage of alarms Education was given on 3/10/11 to nursing staff regarding Alarms and usage of Alarms. C.N.A.'s will do safety checks at the beginning of their shifts. Charge nurse will do safety checks at the beginning of their shift. Charge nurse will document that personal body alarms are in place and working on their TAR (Treatment Administration Record). The systemic change is that all newly hired C.N.A.'s, and annual competencies with all C.N.A.'s will be educated on use of the Hoyer lift. Education was given on 3/10/11 to nursing staff regarding use of the Hoyer lift per facility policy. IV. Unit Manager or	04/06/2011

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	resident had a fall with no injury. The physician order, dated 2/24/11, was a pressure alert pad to bed and wheelchair to alert staff of unassisted transfer. The "Fall Risk Assessment," dated 12/30/10, indicated a total score of 14 with a total score of 10 or above indicated the resident was a high risk for falls. The resident had a fall on 10/06/10 due to attempting to self transfer out of bed. b.) Resident #29's PBA was observed in the "off" position. At this same time during an interview, CNA #12 indicated she had forgotten to turn the PBA on when she had gotten the resident up for this meal as she turned the alarm on now. She indicated the resident should have her alarm on at all times when up in her chair. Resident #29's record was reviewed on 3/07/11 at 8:55 a.m. The resident's diagnoses included, but were not limited to, dementia, debility, osteoporosis, osteoarthritis, macular degeneration - legally blind, compression fracture in 1998, right knee fracture with open reduction in 1999, and neuropathy. The quarterly minimum data set assessment, dated 3/02/11, indicated the resident was		Designee will audit personal body alarms to assure that they are functioning properly on all shifts, 5 residents per week for 30 days, then 5 residents per month for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring. Unit Manager or Designee will audit the use of the Hoyer lift to assure safe and appropriate transfer procedure on all shifts, 5 residents per week for 30 days, then 5 residents per month for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring. The results of the audits will be reported to the QA committee monthly for 12 months to assist with additional recommendations if necessary. Please see revised attachment #3 regarding: Alarm Audit Please see revised attachment #4 regarding: Hoyer Lift-Proficiency of nurse aides. Please see revised attachment #5 regarding: Hoyer Lift. COMPLETION DATE: April 6, 2011.	

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	cognitively severely impaired. The resident required extensive assist of 1 to 2 persons for transfers and toileting. The resident had a recent fall with injury. The physician order, dated 2/24/11, was a clip alarm to her wheelchair to alert staff of unassisted transfer. The "Fall Risk Assessment," dated 2/16/11, indicated a total score of 19 with a total score of 10 or above indicated the resident was a high risk for falls. The nurse's notes indicated the resident had a fall on 2/16/11 at 10:30 a.m. The resident was leaning over in the wheelchair and tumbled forward resulting in a head laceration. The resident was sent to the emergency room where demabond was applied to the area, and the resident returned to the facility. c.) Resident #25's personal body alarm (PBA) was also found in the "off" position with exposed wires at the connection to the boxed alarm. At this same time during an interview, LPN #1 turned the PBA on and indicated she would replace the present PBA due to the exposed wires. Resident #25's record was reviewed on			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	3/04/11 at 11:20 a.m. The resident's diagnoses included, but were not limited to, dementia, osteoporosis, and history of falls. The quarterly minimum data set assessment, dated 2/24/11, indicated the resident's cognition was severely impaired. The resident required extensive assistance of 1 to 2 persons for transfers and toileting. The resident had no recent falls. The physician order, dated 12/27/10 and dated 2/14/11, was a pressure alert pad to bed and wheelchair. The "Fall Risk Assessment," dated 2/13/11, indicated a total score of 6 with a total score of 10 or above indicated the resident was a high risk for falls. The resident had a fall on 3/06/11 at 6:30 a.m. when she had slipped on the floor while sitting on the side of the bed. d.) Resident #44's personal body alarm (PBA) was also found in the "off" position. At this same time during an interview, LPN #1 indicated the alarm should be on as she turned the PBA back on. Resident #44's record was reviewed on 3/07/11 at 9:30 a.m. The resident's			

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	diagnoses included, but were not limited to, dementia and unsteady gait. The resident was admitted on 2/25/11. The physician order, dated 2/25/11, was bed and wheelchair alarm. The "Fall Risk Assessment," dated 2/25/11, indicated a total score of 13 with a total score of 10 or above indicated the resident was a high risk for falls. The nurse's notes, dated 2/25/11, indicated the resident was admitted at 3:00 p.m. The resident was indicated as alert and orientated to name only. Bruising was observed on the left elbow and left hand due to a fall from 2 days ago. e.) On 3/02/11 at 9:00 a.m., Resident #16 was observed in her chair in the lobby in front of the television. She was observed working herself towards the bottom of the chair. Her personal body alarm (PBA) was observed in the "off" position. At this same time during an interview, LPN #19 indicated the PBA was off as she turned it on and repositioned the resident. Resident #16's record was reviewed on 3/04/11 at 10:35 a.m. The resident's diagnoses included, but were not limited to, history of multiple falls, left arm			

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	humerus fracture, left hip fracture with open reduction internal fixation, pelvic fracture in 2009, and dementia - Alzheimer's type. The quarterly minimum data set assessment, dated 1/25/11, indicated the resident's cognition was severely impaired. The resident was extensive care with 1 assist for transfer and toileting. The resident was indicated with no falls since admission/prior assessment. The physician order, dated 2/24/11, was pressure alert pad to bed and wheelchair to alert staff of unassisted transfers. The "Fall Risk Assessment," dated 11/27/10, indicated a total score of 15 with a total score of 10 or above indicated the resident was a high risk for falls. The resident had falls on 11/27/10, 8/21/10, 8/11/10, 7/12/10, 5/23/10, and 5/02/10 where the alarm sounded during the fall. The fall on 11/04/10 at 5:25 p.m. indicated the alarm did not sound due to the alarm was found under the resident. 2. The "Lifting Machine, Using a Portable" policy was provided by the Director of Nursing on 3/03/11 at 8:15 a.m. This current policy indicated the following:			

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	"Purpose The purpose of this procedure is to help lift residents using a manual lifting devices. ...General Guidelines The portable lift can be used by one nursing assistant if the resident can participate in the lifting procedures. If not, two (2) nursing assistants will be required to perform the procedure....." On 3/02/11 from 1:10 p.m. to 1:30 p.m., Resident #13's transfer and personal care was observed. Upon entering the room, CNA #21 was observed to have the resident positioned in the Hoyer lift above the bed as he was lowered to the bed. No other staff personnel were present. CNA #21 then removed the Hoyer lift from the room and returned to this resident's room. At this same time during an interview, CNA #21 said she did complete the resident's Hoyer lift transfer by herself and indicated she did at times if she was unable to find help. She also indicated she knew she was not to transfer the resident by herself. On 3/03/11 at 8:05 a.m. during an interview, the DON indicated Resident #13's Hoyer lift transfer should be			

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	completed with 2 people present, and if not, the staff member was automatically written up. Resident #13's record was reviewed on 3/01/11 at 4:10 p.m. The resident's diagnoses included, but were not limited to, syncope, debility, and Alzheimer's dementia. The significant minimum data set assessment, dated 2/14/11, indicated the resident was moderately cognitively impaired. The resident required total assistance of 2 persons for transfers. The resident had no falls since admission/last assessment. The "Fall Risk Assessment," dated 12/20/10, indicated a total score of 14 with a total score of 10 or above indicated the resident was a high risk for falls. 3.1-45(a)(2)			

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F0328 SS=D	Based on record review, observation and interview, the facility failed to ensure oxygen was administered at the ordered flow rate for 1 of 1 residents observed for oxygen administration (Resident # 80) in a supplemental sample of 19. Findings include: 1. The record for Resident # 80 was reviewed on 3/4/11 at 10 a.m. Physician orders for March 2011, indicated an order for oxygen at 1 liter to be administered continuously by nasal canula. On 3/1/11 at 5:35 p.m., the resident was in the dining room in her wheelchair. Her portable oxygen tank was set at 2 liters. On 3/2/11 at 3:30 p.m., the resident was in bed. Her oxygen concentrator was set at 3 liters and she was wearing the nasal canula. At that time, during interview, LPN # 26 indicated the resident's oxygen should be set at 1 liter. 3.1-47(a)(6)	F0328	**F-328** I. Resident # 80 was assessed and oxygen placed at 1L per order. II. All residents with oxygen were reviewed and found to have oxygen administered per order. III. The systemic change is communicating all oxygen orders on the TAR (Treatment Administration Record) for quick reference. Nursing personnel was educated on 3-10-11 on noting the ordered oxygen rate on the TAR each shift and monitoring for correct settings. IV. The Unit Manager, Director of Nursing/designee will monitor oxygen settings in accordance with the physician's orders on all shifts, 5 residents per week on oxygen settings for 30 days, then 5 residents per month for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring... Results of the audit will be reported to the QA committee monthly for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #6 regarding: Oxygen Audit. COMPLETION DATE: April 6, 2011	04/06/2011

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F0329 SS=D	Based on observations, interviews, and record reviews, the facility failed to ensure non-pharmaceutical interventions were attempted for behaviors prior to the administration of a prn (as needed) medication for 1 of 2 residents reviewed with prn medications for behaviors (Resident #36) and to ensure monitoring of blood pressures were completed as ordered by the physician prior to the administration of blood pressure medicine for 1 of 2 residents reviewed for blood pressure monitoring (Resident #80) in a sample of 19. Findings include: 1. The "Behavior Assessment and Monitoring" policy was provided by the Director of Nursing (DON) on 3/04/11 at 11:25 a.m. This current policy indicated the following: "Policy Statement 1. Problematic behavior will be identified and managed appropriately. ...Policy Interpretation and Implementation ...Management 1. The staff will identify and discuss with	F0329	**F-329** I. Resident #36 was assessed and use of non pharmaceutical approaches in place per resident care plan. Resident # 80 was assessed and blood pressure obtained per the physicians order. II. Residents who are receiving a psychotropic medication were reviewed by the pharmacist for appropriate medical symptoms and or diagnosis to warrant the use of a psychotropic medication. Any recommendation from the pharmacist will be addressed as appropriate by physician or nursing staff, including action for non pharmaceutical interventions. Residents who receive blood pressure medications that require monitoring prior to medication administration have been reviewed and blood pressures obtained as needed. III. The systemic change is review of all PRN orders for psychotropic medications in daily clinical meeting to determine that non drug interventions are planned	04/06/2011

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	the practitioner situations where nonpharmacologic approaches are indicated, and will institute such measures to the extent possible. Monitoring ...2. The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) the following information about specific problem behaviors: ...c. Interventions attempted... d. Outcomes associated with interventions....." 2. On 3/01/11 at 11:15 a.m., Resident #36 was observed in his chair in the lobby next to the nurse's station. At this same time, the resident began yelling for family members. Unit Manager (UM) #1 was observed to go talk to the resident and take him from the lobby to the dining room. In the dining room, UM #1 obtained some drinks for the resident with no further yelling heard. On 3/01/11 at 2:25 p.m., Resident #36 was observed in his chair in front of the television in the lobby next to the nurse's station. As he was heard talking out loud at times, LPN #11 indicated the resident		and that nurses will provide non drug implementation prior to the administration of PRN psychotropic medications by noting in the nurses' notes the non drug intervention. Licensed nurses were provided education on appropriate medical symptoms and or diagnosis to warrant the use of a psychotropic medication, behavior monitoring documentation and non pharmaceutical interventions before administering PRN psychotropic medications. The systemic change is that all new admission's orders and all new orders are going to be reviewed in daily clinical meetings and weekly in At Risk meeting, for orders that require monitoring blood pressure with parameters. Nurses were educated on 3/10/11 on blood pressure including documentation of monitoring blood pressure prior to administering medications that have parameters ordered. IV. The DON/Designee will review 24 hour reports and physician orders for any PRN psychotropic medication administration 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per week for 180 days, to total 12 months of	

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	would be put to bed soon. She indicated he usually was put to bed after lunch. On 3/02/11 at 3:40 p.m. during an interview, the DON indicated behaviors were documented in the nurse's notes and in the computer by the CNA's. On 3/04/11 at 11:45 a.m. at the daily exit conference during an interview, further information was requested from the Director of Nursing concerning Resident #36's non-pharmaceutical/pharmaceutical interventions in 12/10 and 1/11. On 3/07/11 at 8:25 a.m. during an interview, the DON indicated she had no further information concerning the use of non-pharmaceutical interventions for Resident #36's behaviors prior to the administration of Xanax. On 3/07/11 at 1:25 p.m. during an interview, UM #1 indicated with Resident #36 generally one could ask him what he needed, and he could communicate his needs to you, for example, to go to the bathroom. She also indicated at times he would get confused and would yell for his wife, which could be directed with snacks and/or drinks. Resident #36's record was reviewed on		monitoring. The DON/Designee will also review MARs for documentation of blood pressures when parameters to dispense are ordered by a physician, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days for a total of 12 months of monitoring. Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see attachment #7 regarding: 24Hour New/Re-Admission Checklist. Please see attachment #8 regarding: Psychotropic Med Administration & BP Parameter Monitoring Audit COMPLETION DATE: April 6, 2011.	

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	3/02/11 at 12:50 p.m. The resident's diagnoses included, but were not limited to, depression and Alzheimer's disease. The admission minimum data set assessment, dated 12/14/10, indicated the resident's Brief Interview of Mental Status (BIMS) total score was 6, which indicated the resident's cognition was severely impaired. The physician's order, dated 12/13/10, was Xanax 0.5 mg (milligrams) by mouth every day as needed for increased anxiety and to re-evaluate in 14 days. The physician's order, dated 12/27/10, was Xanax 0.5 mg by mouth every day as needed for anxiety. The physician's order, dated 1/07/11, was Xanax 0.5 mg by mouth 2 times a day as needed for anxiety. The nurse's notes indicated on 12/13/10 at 7:30 p.m., the resident was up in his wheelchair (w/c) and was confused. He indicated he did not know why he was here, and his wife was to pick him up. The resident was medicated with Xanax 0.5 mg for increased anxiety. A phone call was also place to his daughter, so the resident can speak with her and "calm down." On this same day at 8:30 p.m., the resident was indicated as calm at this time. No further information was			

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	indicated concerning behaviors. The "Point of Care History (CNA's computer information)," dated 12/13/10, indicated at 9:42 p.m. the resident's behaviors significantly interfered with the resident's care and did disrupt the resident's care and/or living environment. No specific information concerning the behaviors was indicated. The nurse's notes, dated 12/16/10, indicated Xanax was given at 6:00 p.m. due to anxiety. The resident was noted as confused. No information was indicated concerning any non-pharmaceutical interventions attempted prior to the administration of the medication, Xanax. The "Point of Care History," dated 12/16/10, indicated no behaviors had occurred. The nurse's notes, dated 12/18/10, indicated the resident was resting in bed and was alert with periods of confusion this evening. He was given Xanax at 8:00 p.m. due to the physician's order to give for increase agitation. The resident wanted to go home and wanted to know when his wife and daughter would be her to take him home. No information was indicated concerning any			

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	non-pharmaceutical interventions attempted prior to the administration of the medication, Xanax. The "Point of Care History," dated 12/18/10, indicated no behaviors had occurred. The nurse's notes, dated 12/21/10, indicated at 9:20 p.m. the resident was given Xanax at 4:30 p.m. duet to anxiety. The resident was presently in bed. No information was indicated concerning any non-pharmaceutical interventions attempted prior to the administration of the medication, Xanax. The "Point of Care History," dated 12/21/10, indicated no behaviors had occurred. The nurse's notes, dated 12/28/10, indicated Xanax given at 5:00 p.m. No information was indicated concerning any non-pharmaceutical interventions attempted and/or the reason for the administration of the Xanax. The "Point of Care History," dated 12/28/10, indicated no behaviors had occurred. The nurse's notes, dated 12/29/10, at 9:40			

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	p.m. indicated the resident had been quiet most of the shift and had some anxiety around 4:00 p.m. when Xanax was given. No information was indicated concerning any non-pharmaceutical interventions were attempted prior to the administration of the Xanax medication. The "Point of Care History," dated 12/29/10, indicated no behaviors had occurred. The nurse's notes, dated 1/10/11, indicated at 10:55 p.m. Xanax was given at "6:30" due to yelling. No information was indicated concerning any non-pharmaceutical interventions attempted prior to the administration of the medication, Xanax. The "Point of Care History," dated 1/10/11, indicated no behaviors had occurred.			

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F0329 SS=D	3. The record for Resident # 80 was reviewed on 3/4/11 at 10 a.m. Current diagnoses included, but were not limited to, hypertension. Physician orders for March indicated an order for Norvasc 10 milligram daily and to hold the medication if the systolic blood pressure is less than 110. The February 2011 Medication Administration Record lacked blood pressure results prior to administering the Norvasc on 2/11, 12, 13, 14, 15, 16 and 24, 2011. 109/55. On 2/10/11 at 8 a.m., the Norvasc was held due to a blood pressure of 98/64 and was held on 2/26/11 at 8 a.m., due to a blood pressure of During interview on 3/7/11 at 12:45 p.m., the Director of Nursing indicated the blood pressures were not completed. 3.1-48(a)(3) 3.1-48(b)(1)	F0329	**F-329** I. Resident #36 was assessed and use of non pharmaceutical approaches in place per resident care plan. Resident # 80 was assessed and blood pressure obtained per the physicians order. II. Residents who are receiving a psychotropic medication were reviewed by the pharmacist for appropriate medical symptoms and or diagnosis to warrant the use of a psychotropic medication. Any recommendation from the pharmacist will be addressed as appropriate by physician or nursing staff, including action for non pharmaceutical interventions. Residents who receive blood pressure medications that require monitoring prior to medication administration have been reviewed and blood pressures obtained as needed. III. The systemic change is review of all PRN orders for psychotropic medications in daily clinical meeting to determine that non drug interventions are planned	04/06/2011

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			and that nurses will provide non drug implementation prior to the administration of PRN psychotropic medications by noting in the nurses' notes the non drug intervention. Licensed nurses were provided education on appropriate medical symptoms and or diagnosis to warrant the use of a psychotropic medication, behavior monitoring documentation and non pharmaceutical interventions before administering PRN psychotropic medications. The systemic change is that all new admission's orders and all new orders are going to be reviewed in daily clinical meetings and weekly in At Risk meeting, for orders that require monitoring blood pressure with parameters. Nurses were educated on 3/10/11 on blood pressure including documentation of monitoring blood pressure prior to administering medications that have parameters ordered. IV. The DON/Designee will review 24 hour reports and physician orders for any PRN psychotropic medication administration 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per week for 180 days, to total 12 months of	

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			monitoring. The DON/Designee will also review MARs for documentation of blood pressures when parameters to dispense are ordered by a physician, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180 days for a total of 12 months of monitoring. Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see attachment #7 regarding: 24Hour New/Re-Admission Checklist. Please see attachment #8 regarding: Psychotropic Med Administration & BP Parameter Monitoring Audit COMPLETION DATE: April 6, 2011.	

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F0363 SS=E	Based on observation, interview and record review, the facility failed to ensure menus were followed for 6 of 6 residents with physician's orders for a no concentrated sweets diet in a supplemental sample of 19 (Resident #65, #31, #67, #79, #81 and #82). Of the facility's 93 residents, 25 of 25 residents with a physician's order for a no concentrated sweets diet, had the potential to be impacted by this deficient practice. Findings include: 1.) During a 3/4/11,	F0363	**F-363** I. Residents #65, #67, #31, #79 #81 and #82 were assessed and menus were reviewed to provide diets in accordance to the physician's orders. II. All diabetic residents have been reviewed by the registered Dietician. Diets have been reviewed and recommendations have been addressed. III. The systemic change is that the menu system was revised to include appropriate diets for diabetics with orders for alteration of sugar content Nursing personnel were educated on 3-10-11 on providing appropriate diets. Dietary personnel were educated on 3-15-11 and 3-22-11 on providing appropriate diets. IV. The Dietary Service Manager will determine appropriate diets are provided to residents for all three meals, by auditing 5 residents per week for 30 days, then 5 residents per month for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #9 regarding: Dietary Audit Tool COMPLETION DATE: April 6, 2011.	04/06/2011

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	9:15 a.m., the Administrator indicated 25 of the facility's 93 residents had physician's orders for a No Concentrated Sweets/Restricted Carbohydrate or Carbohydrate Controlled Diet, which were all the same diet per facility practice. 2.) During a 3/4/11, 11:10 a.m., interview, the Administrator indicated dietary staff are train to follow menus and spreads sheets (menu portion size			

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	guides) and expected to follow menus and spread sheets. 3.) Review of a current, 3/04, facility document titled "Job Specific Orientation-Dietary Cook", which was provided by the Administrator on 3/4/11 at 11:12 a.m. indicated the following: "...training is completed... Menu Cycles: Therapeutic Diets... Menu recipes per # served...			

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	Follow menus, record substitutions..." A review of current,1/25/10, facility menus and spread sheets, which were provided by the Food Services Supervisor on 3/1/11 at 1:00 p.m., indicated the following: Tuesday 3/1/11 lunch- no concentrated sweets and/or restricted carbohydrate diets were menued to receive an open faced (1/2 bun, bottom bun no top)			

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	cheeseburger. Tuesday 3/1/11 supper- no concentrated sweets and/or restricted carbohydrate diets were menued to receive 3/4th's of a Belgian waffle with restricted carbohydrate/sugar syrup. Review of an undated, facility policy titled, "Open Faced Sandwiches", which was provided by the Administrator on 3/2/11 at 8:50 a.m., indicated			

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	the following: "Any sandwich is to be served open face is to be served with 1 slice bread or 1/2 bun..." 4.) During a 3/1/11, 11:10 a.m., interview, Cook #25 indicated she thought an open faced sandwich was a sandwich served with both sides of the bun open on the plate with toppings (lettuce, tomato, cheese, onion) on the top bun and the hamburger on the bottom bun. She indicated she			

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	did not understand that an open faced sandwich contained only one slice of bread or half a bun. 5.) Resident #65's record was reviewed 3/4/11 at 10:30 a.m. Resident #65's current diagnoses included, but were not limited to, diabetes and dementia. Resident #65 had a current, 2/9/11,physician's order for a no concentrated sweets diet.			

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	Resident #65 record indicated the resident had a resent history of blood sugar results greater than 400 on 2/19/11 and 2/26/11. Resident #65 had a, 11/18/10, current care plan problem/need regarding diabetes and a potential for unstable blood sugars. An approach to this problem was to serve the resident a diet per physician's order. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	meal service observation, Resident #65 was served a cheeseburger with both a top and bottom bun (2 slices of bread). Resident #65 consumed the sandwich. 6.) Resident #67's record was reviewed on 3/4/11 at 10:00 a.m. Resident #67's current diagnoses included, but were not limited to, diabetes and dementia. Resident #67 had a current, 9/21/10,			

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	physician's order for a no concentrated sweets diet. Resident #67 had a current, 12/10, care plan problem/need regarding diabetes. An approach to this problem was to serve a diet as ordered by the physician. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #67 was served a cheeseburger with both a top and bottom bun (2 slices of bread). Resident #67 consumed			

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	the sandwich. 7.) Resident #31's record was reviewed 3/4/11 at 10:15 a.m. Resident #31's current diagnoses included, but were not limited to, diabetes and dementia. Resident #31 had a current, 2/11, physician's order for a no concentrated sweets diet in a mechanical soft texture. Resident #31 had a current, 11/10, care plan			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	problem/need regarding diabetes. An approach to this problem was to serve a diet as ordered by the physician. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #31 was served a ground meat cheeseburger with both a top and bottom bun (2 slices of bread). Resident #31 consumed the sandwich.			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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F0363 SS=E	8. The record for Resident # 79 was reviewed on 3/7/11 at 10:40 a.m. The March 2011 physician orders indicated an order for a regular no concentrated sweet diet. During the super meal observation on 3/1/11 at 5:25 p.m., the resident was served a full size waffle and ate 100 % of the waffle. 9. The record for Resident # 81 was reviewed on 3/7/11 at 10 a.m. The March 2011 physician orders indicated an order for a regular no concentrated sweet diet. During the super meal observation on 3/1/11 at 5:25 p.m., the resident was served a full size waffle and was given a regular syrup. 10. The record for Resident # 82 was reviewed on 3/7/11 at 10:45 a.m. The March 2011 physician orders indicated an order for a regular carbohydrate controlled diet. During the super meal observation on 3/1/11 at 5:35 p.m., the resident was	F0363	**F-363** I. Residents #65, #67, #31, #79 #81 and #82 were assessed and menus were reviewed to provide diets in accordance to the physician's orders. II. All diabetic residents have been reviewed by the registered Dietician. Diets have been reviewed and recommendations have been addressed. III. The systemic change is that the menu system was revised to include appropriate diets for diabetics with orders for alteration of sugar content Nursing personnel were educated on 3-10-11 on providing appropriate diets. Dietary personnel were educated on 3-15-11 and 3-22-11 on providing appropriate diets. IV. The Dietary Service Manager will determine appropriate diets are provided to residents for all three meals, by auditing 5 residents per week for 30 days, then 5 residents per month for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #9 regarding: Dietary Audit Tool COMPLETION DATE: April 6, 2011.	04/06/2011

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	served a full size waffle and 2 regular syrups by RN # 28. A few minutes later, LPN # 26 assisted the resident to cut up her waffle, he at that time indicated the resident needed sugar free syrup. During an interview with LPN # 26 on 3/1/11 at 6 p.m., he indicated he was aware sugar free syrup was not served and he had reminded the staff to watch the tray cards. 3.1-20(i)(4)			

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F0365 SS=D	Based on observation, interview and record review the facility failed to ensure residents who had physician's orders for a pureed diet with food items thinned to a nectar consistency, were served diets in the nectar thick form for 2 of 2 residents reviewed with orders for a pureed nectar thick foods diet in a sample of 19 (Residents #77 and #91). Findings include:	F0365	**F-365** I. Residents #77 and #91 were assessed and provided appropriate diets in accordance to physician's orders. II. The Registered Dietician and Speech Therapist reviewed all the residents on pureed diet with nectar thick consistency, on 3/21/11. Following the review all diets were provided in appropriate consistency... III. The systemic change is that a new recipe for preparing puree foods to nectar-Like consistency was put into place. Dietary personnel were educated on the new recipe of preparing pureed foods with nectar like consistency on 3/2/11 and 3/3/11 IV. The Dietary Service Manager will monitor that puree diets and the new recipe are followed for all three meals, by auditing 5 residents per week for 30 days, then 5 residents per week for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring . Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please See revised attachment #9 regarding: Dietary Audit Tool. COMPLETION DATE: April 6, 2011.	04/06/2011

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	1.) A review of current,1/25/10, facility menus and spread sheets (portion size guides), which were provided by the Food Services Supervisor on 3/1/11 at 1:00 p.m., lacked any indication of portion sizes or a category for a " thinned pureed diet with food in a nectar thick consistency." 2.) During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Cook #25 indicated she was preparing the "thinned			

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	pureed diets." She place pureed food items in coffee mugs. She added broth juice or gravy to the coffee mugs. She stirred the mixture with a knife and served the items to the residents #77 and #91. 3.) During a 3/2/11, 9:00 a.m., interview, Cook #25 indicated she had not received any training regarding how to prepare the a pureed diet with food items thinned to nectar constancy. She indicated the first day she got the			

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	order, she had no idea what to do so she asked a nurse for guidance. Cook #25 indicated the nurse had told her to thin the pureed food items with broth or juice and stir then stop adding broth when the item appeared thin enough to drink. Cook #25 indicated she had not had any training from the speech therapy department or a dietary supervisor regarding how to prepare thinned pureed foods. Cook #25 indicated there was no recipe or directions			

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RAWLINS HOUSE HEALTH & LIVING COMMUNITY, LLC	300 J H WALKER DRIVE PENDLETON, IN46064

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	regarding thinned pureed foods in the menus, recipe book or any other dietary manual. 4.) During a 3/2/11, 8:05 a.m., interview the Director of Nursing indicated the facility did not have directions for the preparation of a pureed foods at nectar consistency until the afternoon of 3/1/11 following inquires by the survey team. The Director of Nursing indicated a new policy had been developed and provided the policy at			

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	the time of the interview. The new, undated, facility policy titled "Directions for Preparing Pureed Food to Nectar-Like Consistency", which was provided by the Director of nursing on 3/2/11 at 8:05 a.m., indicated the following: "For all hot meats and vegetables add 1/2 cup warm milk to each item and stir until blended. Check consistency (the beverage should coat and drip off the spoon similar			

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	to unset gelatin). Continue adding warm milk until correct consistency is obtained." 5.) During a 3/4/11, 9:15 a.m., interview, the Administrator indicated 2 of the facility's residents had physician's orders for a thinned pureed diet. 6.) Resident #77's record was reviewed on 3/1/11 at 3:00 p.m. Resident #77's current diagnoses included, but were not limited to,			

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	dysphagia and dementia. Resident #77 had a current, 2/24/11, physician's order to modify diet to a "thinner pureed consistency (nectar like) for all meals but continue thin liquids. Present all food/liquids in coffee mugs." Resident #77 had a 2/21/11, "PLAN OF TREATMENT" for speech therapy which indicated: "...seen at lunch to assess pt's [patients] swallow. ...would not/could not			

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	chew any foods that were put in mouth. Pt able to suck on straw given 50% cueing to suck and take drink. Pt was seen later in day with food from lunch still in mouth unable to swallow..." Resident #77 had a ,2/24/11, "Patient Specific Training" speech therapy form which indicated: "1.)... thinner puree consistency (nectar-like) for all meals. 2.) continue thin liquids 3.) all food/liquids to be			

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	presented in cups (preferably coffee mugs)..." The area of the form which was signed by staff who had receives "training on the above recommendations" was signed by only one employee, LPN #5. During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Resident #77 was served the thin pureed which was served in mugs and prepared using the above indicated method.			

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	Resident #77 was assisted and cued by staff to drink the pureed liquid using a straw. The pureed liquids were observed to be in varying forms of thickness. The appearance of the liquids ranges from thin (a thickness that would drip from a spoon leaving no residue behind) to honey thick (a thickness that would cling to the spoon, drip slowly and leave a noticeable coating behind.)			

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SS=D	7. The record for Resident # 91 was reviewed on 3/1/11 at 3:45 p.m. Current diagnoses included, but were not limited to, dysphagia and dementia. A physician order dated 2/24/11 indicated an order from the speech therapist for a thinner puree diet (nectar consistency) with thin liquids. On 3/1/11 at 11:00 a.m., during the lunch meal observation, the resident was served 3 teacups of a puree substance. She used a spoon to feed herself and also drank from the cups. During the super meal observation on 3/1/11 at 5:25 p.m., the resident was served a plate of puree food items in a normal puree form. She picked up her spoon and began feeding herself. At that time, RN # 28 was queried if the resident was served the correct diet. She removed the resident's plate after explaining to the resident, then she checked the resident's record. She then indicated the resident was served the wrong consistency puree food. During interview on 3/3/11 at 2:30 p.m.,		**F-365** I. Residents #77 and #91 were assessed and provided appropriate diets in accordance to physician's orders. II. The Registered Dietician and Speech Therapist reviewed all the residents on pureed diet with nectar thick consistency, on 3/21/11. Following the review all diets were provided in appropriate consistency... III. The systemic change is that a new recipe for preparing puree foods to nectar-Like consistency was put into place. Dietary personnel were educated on the new recipe of preparing pureed foods with nectar like consistency on 3/2/11 and 3/3/11 IV. The Dietary Service Manager will monitor that puree diets and the new recipe are followed for all three meals, by auditing 5 residents per week for 30 days, then 5 residents per week for 150 days, then 3 residents per month for 180 days to total 12 months of monitoring . Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please See revised attachment #9 regarding: Dietary Audit Tool. COMPLETION DATE: April 6, 2011.	04/06/2011

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	with Speech Therapist # 29, she indicated the resident was having difficulty swallowing the regular puree diet so she wanted the resident on a thinner puree nectar consistency diet to increase her intake. She indicated the former Dietary Manager had been trained on the thinner puree but she had not trained the new Dietary Manager. 3.1-21(a)(3)			

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F0371 SS=E	Based on observation, interview and record review the facility failed to ensure employees used appropriate utensils to serve foods and employees washed their hands in a manner to prevent the potential spread of infection or decrease potential risk of contamination. Of the facility's 93 residents, this deficient practice had the potential to impact 59 of 59 residents who received meals prepared and served from the main kitchen and main dining room.	F0371	**F-371** I. Employee number 25 was immediately educated on handling food with proper utensils and hand washing on 3/1/2011. Employee numbers #30, #31, #2, #3, #4, #5, #6, #7, #9, #10, , #13, #14, #15, #16, #1, #17 have been educated on hand washing. II. Education to dietary staff was provided regarding hand washing. on 3/1/11. III. The systemic change is that a new automatic towel dispenser was replaced. All new hires and on annual competency will be educated on hand washing. All new dietary hires and annual competency will be educated on hand washing and use of gloves. IV. The Director of Nursing and or Designee will audit all staff on hand washing and towel dispensing on all shifts, with, 5 staff members per week for 30 days, then 5 staff members per month for 150 days, then 3 staff members per month for 180 days to total 12 months of monitoring to ensure infection control practices are followed. Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #10 regarding: Hand Washing & Paper Towel dispensing Audit. Please see revised attachment #11 regarding: Hand Washing. COMPLETION DATE: April 6, 2011.	04/06/2011

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	Findings include: 1.) Review of a current, 3/2/11, facility policy, titled "Personal Hygiene of Food Handlers", which was provided by the Administrator on 3/2/11 at 8:50 a.m., indicated the following: "Use of Gloves and Sanitized Utensils: ...b. Sanitized utensils will be used to prevent bare hand contact with ready-to-eat foods in			

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order to reduce potential doe transmission of bacterial or viral agents."

2. The "Handwashing/Hand Hygiene" policy was provided by the DON (Director of Nursing) on 3/04/11 at 11:25 a.m. This current policy indicated the following:

"Policy Statement

This facility considers hand hygiene the primary means to prevent the spread of infections.

Policy Interpretation and Implementation

...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:

...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);
...g. Before and after assisting a resident with meals...."

3.) During a 3/7/11, 2:00 p.m. interview, the Administrator indicated

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	59 of the facility's 93 residents either eat meals in the main dinning room or receive room trays that were prepared for distribution in the main dinning room's adjoining kitchen. 4.) During a 3/1/11, 11:05 a.m. to 12:00 p.m., lunch meal service observation, Cook #25 was observed in the main dining rooms adjoining kitchen preparing plates of food for distribution to residents. Cook #25 wore gloves on both hands. With her gloved			

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	hands she touched bread bags, menu cards, counter tops, food carts (handles, zippers, covers and sides), scoop handles and food trays. With the same contaminated gloves, she picked up buns, cheese, lettuce, tomatoes and onions and placed them on residents plates. She continued this process throughout the meal service process. Cook #25 was observed to serve 15 residents their meal tray using this same process of handling food with her contaminated			

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	gloves. 5.) During a 3/2/11, 7:40 a.m., breakfast meal observation in the main dining room, Admissions Coordinator #30 was observed passing meal trays. Admissions Coordinator #30 went to the sink in the main dining room in order to wash her hands. Admissions Coordinator #30 advanced the paper towel prior to washing her hands. In order to prevent the towel from hitting the faucet, Admission Coordinator			

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	#30 use her unwashed soiled hand to guide the paper towel behind the faucet. She completed her handwash and then dried her hands on the paper towel she had contaminated when guiding the paper towel behind the faucet. She then went to the food service area and obtained another resident food tray for distribution. 6.) During a 3/2/11, 7:41 a.m., breakfast meal observation in the main dining room, CNA #31 was observed passing			

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	meal trays. CNA #31 went to the sink in the main dining room in order to wash her hands. CNA #31 advanced the paper towel prior to washing her hands. In order to prevent the towel from contacting the faucet, CNA #31 use her unwashed soiled hand to guide the paper towel behind the faucet. She completed her handwash and then dried her hands on the paper towel she had contaminated when guiding the paper towel behind the faucet. She			

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	then went to the food service area and obtained another resident food tray for distribution.			

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F0371 SS=E	7. On 3/01/11 from 11:35 a.m. to 12:00 p.m. during lunch observation, as drinks were being served to the residents, the following was observed: CNA #2 was observed to dispense paper towel with the paper towel pumping lever with one hand and with her other hand she guided this same paper towel down from the dispenser to behind the faucet. After she completed her handwashing, she used this same towel to dry her hands. Activity Assistant #3 was also observed to use one hand to guide the paper towel down as she dispensed the towel with the lever with the other hand. After handwashing, she used this same towel to dry her hands. Next, LPN #4 was observed to dispense a piece of paper towel, turned the water on with this same paper towel and set it to the side of the sink, handwashed, and then used the same paper towel to dry her hands and turn the water off. She then proceeded to assist a resident with his blanket removing the blanket due to spilled cocoa on it. She left the dining room with the unbagged blanket. LPN #5 was observed to dispense the paper towel, placed it under her arm next	F0371	**F-371** I. Employee number 25 was immediately educated on handling food with proper utensils and hand washing on 3/1/2011. Employee numbers #30, #31, #2, #3, #4, #5, #6, #7, #9, #10, , #13, #14, #15, #16, #1, #17 have been educated on hand washing. II. Education to dietary staff was provided regarding hand washing. on 3/1/11. III. The systemic change is that a new automatic towel dispenser was replaced. All new hires and on annual competency will be educated on hand washing. All new dietary hires and annual competency will be educated on hand washing and use of gloves. IV. The Director of Nursing and or Designee will audit all staff on hand washing and towel dispensing on all shifts, with, 5 staff members per week for 30 days, then 5 staff members per month for 150 days, then 3 staff members per month for 180 days to total 12 months of monitoring to ensure infection control practices are followed. Results of the audits will be reported to the QA Committee monthly for 12 months, to assist with additional recommendations if necessary. Please see revised attachment #10 regarding: Hand Washing & Paper Towel dispensing Audit. Please see revised attachment #11 regarding: Hand Washing. COMPLETION DATE: April 6, 2011.	04/06/2011

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	to her uniform, handwashed, and then used the same paper towel from under her arm to dry her hands. CNA #2 was again observed to handwash. After she dispensed the paper towel behind the faucet leaving an accumulated amount of paper towel on the counter, she handwashed getting the paper towel behind the faucet wet. This same paper towel was used to dry her hands, and then, she was observed to wipe the excess water off from around the sink. CNA #6 was observed to dispense the paper towel while guiding it down with her other hand behind the faucet. After handwashing, she dried her hands with this same paper towel. RN #7 was observed to dispense the paper towel behind the faucet. After handwashing, she used this same towel to dry her hands. No handgel use was observed during these observations. 8. On 3/01/11 from 12:13 p.m. to 1:10 p.m. during lunch observation as food trays were being served, the following was observed:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	Speech Therapist #8 was observed to handwash adjusting the water 2 different times during this handwash, turned the water off and dispensed a piece of paper towel with her wet hand before she dried her hands with the paper towel. CNA #9 was observed to handwash, used the side of her hand to dispense the paper towel, and used this same paper towel to dry her hands. CNA #10 was observed to handwash, dispense the paper towel with her wet hand, and then, dried her hands. LPN #5 was observed to dispense the paper towel, tear it off and positioned it under her arm. After she handwashed, she dried her hands with this same paper towel from under her arm. No handgel use was observed during these observations. 9. On 3/01/11 from 5:30 p.m. to 6:25 p.m. during the dinner observation while drinks and food trays were being served, the following was observed: Activity Assistant #13 was observed to dispense the paper towel and guide it down behind the faucet with her hands,			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	handwashed, and used this same paper towel to dry her hands. CNA #14 was observed to dispense the paper towel and guide it down behind the faucet with her hands, handwashed, and used this same towel to dry her hands. Unit Manager #15 was observed to handwash, used her wet hand to dispense the paper towel, which was used to dry her hands. QMA (Qualified Medication Assistant) #16 was observed to handwash, dispense the paper towel with her wet hand, and dried her hands with this same paper towel during 2 different observations. Unit Manager #1 was observed to handwash, dispense the paper towel with her wet hand, and dried her hands with the same paper towel. CNA #17 was observed to dispense the paper towel guiding it behind the faucet with her hand, handwashed, and used this same towel to dry her hands. On 3/04/11 at 11:45 a.m. during an interview, the DON indicated one should dispense the paper towel, handwash for 15 to 20 seconds, dry one's hands with the			

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	paper towel, and then, turn off the water with the same paper towel. 3.1-21(i)(2)			

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F0441 SS=E	Based on observations, interviews, and record review, the facility failed to ensure handwashing/glove use for 1 of 3 nurses observed (LPN #22) during dressing changes and for 3 of 4 nursing staff observed during personal care observations (CNA #'s 12, 21, and 20) and to ensure linen handling for 2 of 4 staff personnel observed (CNA #20 and Dietary Aide #23) during linen handling, and to ensure the handling of medications during medication pass for 1 of 4 nurses observed (LPN #24) were performed in a manner to prevent the spread of infection and diseases. This had the potential to affect 5 of 93 residents observed during the survey. (Resident #'s 36, 28, 13, 26, and 27) Findings include: 1. The "Handwashing/Hand Hygiene" policy was provided by the DON (Director of Nursing) on 3/04/11 at 11:25 a.m. This current policy indicated the following: "Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections.	F0441	**F-441** I. Residents #36, #28, #13, #26 and #27 were reviewed and have had no signs or symptoms of infection requiring antibiotic use since survey completion. All identified staff were provided education immediately to include hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. II. All appropriate nursing staff will be offered education regarding hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. III. The systemic change includes that all newly hired Nurses will receive education for appropriate infection control practice during medication pass and dressing changes. In addition, all newly hired nursing personnel will receive education on hand washing, glove use and handling linen. All current nurses will be offered education hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. IV. Director of Nursing and or designee will audit through direct observations on hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass on all shifts, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180	04/06/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Policy Interpretation and Implementation ...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: ...c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); ...g. Before and after assisting a resident with meals; h. Before and after assisting a resident with personal care (e.g., oral care, bathing); ...k. Before and after changing a dressing; l. Upon and after coming in contact with a resident's intact skin, (e.g., when taking a pulse or blood pressure, and lifting a resident); ...n. Before and after assisting a resident with toileting (hand washing with soap and water); ...q. After contact with a resident's mucous membranes and body fluids or excretions; r. After handling soiled or used linens, dressings, bedpans, catheters and urinals; s. After handling soiled equipment or utensils; ...u. After removing gloves or aprons;...		days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months, to assist with additional recommendations as necessary. See revised attachment #10 regarding: Hand washing & Paper Towel Dispensing Audit. See revised attachment #11 regarding: Hand Washing. COMPLETION DATE: April 6, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	8. The use of gloves does not replace handwashing/hand hygiene. ...Procedure Washing Hands ...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds under a moderate stream of running water,... 3. Rinse hands thoroughly under running water... 4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel....." The "Personal Protective Equipment - Using Gloves" policy was provided by the DON (Director of Nursing) on 3/04/11 at 11:25 a.m. This current policy indicated the following: "...Objectives 1. To prevent the spread of infection; 2. To protect wounds from contamination; 3. To protect hands from potentially infectious material;... ...Miscellaneous ...5. Wash hands after removing gloves.			

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	(Note: Gloves do not replace handwashing.)...." The "Making an Unoccupied Bed" policy was provided by the don on 3/07/11 at 1:55 p.m. This current policy indicated the following: "Purpose The purpose of this procedure is to provide the resident who is able to get out of bed with a clean, comfortable bed. ...General Guidelines ...2. Do not shake the bed linen. Shaking the linen will spread germs throughout the room....." 2. On 3/01/11 from 2:35 p.m. to 2:55 p.m., Resident #36's personal care was observed after he was transferred to the toilet. CNA #12 with gloved hands assisted the resident and wiped him with the toilet paper as he was continent of a large bowel movement. After she removed her gloves, she was observed to begin handwashing. During this observation when the towel dispenser failed to work, CNA #12 was observed to open the paper towel dispenser with her wet hand, repositioned the paper towel roll while dripping on the paper towel roll before she closed it and dried her hands.			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	3. On 3/02/11 from 10:30 a.m. to 10:40 a.m., Resident #28's personal care was observed. With gloved hands, CNA #20 had completed incontinent care and was bagging the linen. She indicated the resident had been incontinent of urine. CNA #20 then removed her gloves and handwashed for less than 10 seconds after she had repositioned the resident in her bed. As she exited the room, CNA #20 indicated she had to go get help to transfer the resident to her wheelchair (w/c). On 3/02/11 from 10:45 a.m. to 11:05 a.m., Resident #28's Hoyer lift transfer was observed. CNA #20 and CNA #21 were observed to hook the Hoyer lift to the sling and completed the transfer of the resident from her bed to her wheelchair. CNA #21 then removed the Hoyer lift from the room and continued down the hallway. No gloves, handwashing, or handgel was observed used. After the resident's top was removed, CNA #20 donned a pair of gloves and continued to dress the resident with her bra and top. After repositioning her in her wheelchair, she proceeded to clean up her room. After removing her gloves, CNA #20 was observed to shake open the resident's quilt over the top of her bed to position it on the resident's bed and then, to place a side			

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	tray onto the resident's wheelchair before handgel was observed used as CNA #20 left the room. 4. On 3/02/11 from 1:10 p.m. to 1:30 p.m., Resident #13's transfer with the Hoyer lift and personal care were observed. Upon entering the room, CNA #21 was observed to be completing the resident's transfer from his wheelchair to his bed. After the transfer was complete, CNA #21 removed the Hoyer lift from the room. After CNA #21 returned to the resident's room, she lowered the resident's F/C bag down below the bladder and proceeded to undress the resident. Next, CNA #21 with gloved hands was observed to complete the resident's personal care. After putting a new brief on, the resident was repositioned and covered up to his chin before CNA #21 removed her gloves. Next, CNA #21 was observed to handwash for 10 seconds. Next, she was observed to open the towel dispenser with her wet hand and repositioned the paper towel roll before she was able to dry her hands. At this same time during an interview, CNA #21 indicated these paper towel holders did not always work. Before CNA #21 exited the room, she applied 2 more blankets on the resident per his request and repositioned the call light and bedside			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

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	table. She then collected her bagged trash, urinal, and soiled linen and left the room. No further handwashing or handgel use was observed. 5. On 3/04/11 at 11:45 a.m. during an interview, the DON indicated one should dispense the paper towel, handwash for 15 to 20 seconds, dry one's hands with the paper towel, and then, turn off the water with the same paper towel. 6. On 3/03/11 from 8:40 a.m. to 9:20 a.m., Resident #28's dressing change on her right ankle was observed. LPN #22 was observed to handwash for less then 10 seconds, donned a pair of gloves, checked the resident's present dressing, removed her protective boots, and repositioned her feet for the dressing change. After the open area was cleansed and treatment applied, LPN #22 was observed to handwash for less than 10 seconds, removed her scissors from her pocket, cut a piece of "CoverRoll" 2 different times, donned a pair of gloves both times, applied each piece of the tape (CoverRoll) to the dressing, and then, removed her gloves each time. After the resident was repositioned, LPN #22 was observed to handwash for less than 15 seconds before exiting the room. At this same time during an interview, LPN #22			

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	indicated one should handwash for 20 seconds. She also indicated one should handwash before and after glove use. 7. On 3/07/11 at 9:44 a.m., Dietary Aide #23 was observed 2 different times to shake open a folded tablecloth to position it on a dining room table in preparation for the lunch meal. On 3/07/11 at 1:05 p.m. during an interview, Dietary Aide #23 indicated she would apply the tablecloths on the dining room table in a manner to be sure they were "neat on top." On 3/07/11 at 1:55 p.m. during an interview, the DON indicated a tablecloth should be laid out and unfolded on the top of the table and not shook out to position it on the dining room tables.			

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	155357	A. BUILDING _____ B. WING _____	03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0441 SS=E	8. During a medication pass observation on 3/1/11 at 3 p.m., LPN # 24, she retrieved a dropper bottle of morphine out of the medication carried it into the resident # 26's room and administered the medication. She then went into the bathroom and sat the dropper bottle on the back of the toilet and washed her hands. She picked up the dropper bottle and carried to the medication cart and placed it into the drawer. 9. During a medication pass observation on 3/1/11 at 3:15 p.m., LPN # 24, retrieved eye drops out of the medication cart and entered Resident # 27's room. She opened the eye drops and placed the cap clean side down onto the bedside table. When she finished administering the eye drops, she picked up the cap and placed it on the bottle. 3.1-18(l) 3.1-19(g)	F0441	**F-441** I. Residents #36, #28, #13, #26 and #27 were reviewed and have had no signs or symptoms of infection requiring antibiotic use since survey completion. All identified staff were provided education immediately to include hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. II. All appropriate nursing staff will be offered education regarding hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. III. The systemic change includes that all newly hired Nurses will receive education for appropriate infection control practice during medication pass and dressing changes. In addition, all newly hired nursing personnel will receive education on hand washing, glove use and handling linen. All current nurses will be offered education hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass. IV. Director of Nursing and or designee will audit through direct observations on hand washing procedure, glove use, linen handling and appropriate infection control practice during medication pass on all shifts, 5 times per week for 30 days, then 5 times per month for 150 days, then 3 times per month for 180	04/06/2011

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			days to total 12 months of monitoring. Results of the audits will be reported to QA monthly for 12 months, to assist with additional recommendations as necessary. See revised attachment #10 regarding: Hand washing & Paper Towel Dispensing Audit. See revised attachment #11 regarding: Hand Washing. COMPLETION DATE: April 6, 2011.	